



Enrollment Application

February 20, 2009

What Steps Do I Take?

- ☐ Read, complete the *Enrollment Application* and sign the *Informed Consent and Release of Medical Information and Affidavit of Wyoming Residency*;
- ☐ Include copies of applicant's last year's Income Tax Return; and
- ☐ Mail or Fax the above-mentioned information to the WCCEDP (address is provided on the *Enrollment Application*).

The WCCEDP will determine your eligibility to participate. There are a few simple eligibility guidelines. Once the program has determined your eligibility, you will receive your determination letter by mail. If you need more enrollment forms for others in your home or friends or family that is over 50 or if you have any questions please contact us at 866-205-5292 or via e-mail at alice.preheim@health.wyo.gov.

Colon Cancer Terms and Definitions

Colonoscopy - This is a test that looks for polyps in the entire colon. A doctor puts a long, flexible tube inside the anus and in the entire colon to allow him or her to see any polyps inside. Most polyps can be removed during the test. This test is usually done every 10 years or as recommended by your doctor.

Crohn's Disease - Crohn's disease is an ongoing disorder that causes inflammation of the digestive tract, also referred to as the gastrointestinal (GI) tract.

Double-Contrast Barium Enema - This test is conducted in a radiology center or hospital. This procedure involves taking x-rays of the rectum and colon after you are given an enema with a barium solution, followed by an injection of air.

Familial Adenomatous Polyposis (FAP) - **Familial** means that it runs in families. Each child of an affected parent has a 50% risk of inheriting the disease gene. **Adenomatous** is a type of mushroom-shaped growth or polyp, which may be precancerous. **Polyposis** is a condition where 100 or more polyps can form in the large intestines.

Fecal Occult Blood Test (FOBT) - A test that checks for hidden blood in the stool with a test kit you use at home. The doctor's office or a lab, check the kit for blood when it is returned.

Flexible Sigmoidoscopy - Flexible sigmoidoscopy is conducted at the doctor's office, clinic, or hospital. The doctor uses a narrow, flexible, lighted tube to look at the inside of the rectum and the lower portion of the colon.

Hereditary Non-Polyposis Colorectal Cancer (HNPCC) - Also known as, the Lynch syndrome is an inherited cause of cancer of the bowel.

Inflammatory Bowel Disease (IBD) - Inflammatory bowel disease is the name of a group of disorders that cause the intestines to become inflamed (red and swollen).

Polyp - An abnormal, often precancerous growth of tissue (colorectal polyps are growths of tissue inside the intestine).

Sources for definitions: National Cancer Institute and Centers for Disease Control and Prevention.

2009 Federal Poverty Guidelines

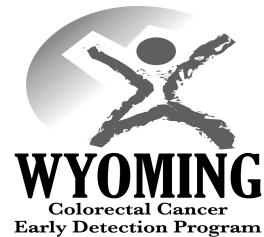
Number of Persons in Family Unit	Poverty Line	250% of Poverty Line
1	\$10,830	\$27,075
2	\$14,570	\$36,425
3	\$18,310	\$45,775
4	\$22,050	\$55,125
5	\$25,790	\$64,475
6	\$29,530	\$73,825
7	\$33,270	\$83,175
8	\$37,010	\$92,525
Each additional person, add	\$3,740	\$9,350

The Wyoming Colorectal Cancer Early Detection Program uses 250% poverty guidelines to determine eligibility. Poverty guidelines are updated annually by the federal government. They are usually released by mid-February of that year. You can find the current poverty guidelines with calculated percentages at

<http://www.cms.hhs.gov/medicaid/eligibility/>

Wyoming Colorectal Cancer Early Detection Program

Enrollment Application



1. All questions must be answered on BOTH SIDES. Please print in black ink.
2. Return this form with the *Informed Consent and Release of Medical Information*, and the *Affidavit of Wyoming Residency* to the Wyoming Colorectal Cancer Early Detection Program.

First Name		Initial	Last Name		Maiden Name (if applicable)
Address		City	State	Zip	Birth Date / /
Home Phone ()	Work Phone ()	Best time to reach you:			
Cell Phone ()				How did you hear about the program?	
In case of Emergency: Contact person: _____ Relationship: _____ Phone: () _____ Address: _____ City: _____ State: _____ Zip: _____				<input type="checkbox"/> Doctor <input type="checkbox"/> Breast & Cervical Program <input type="checkbox"/> Family <input type="checkbox"/> Community Event <input type="checkbox"/> Mailing/Flyer <input type="checkbox"/> Other healthcare provider <input type="checkbox"/> Other _____	
What race are you? <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				Are you of Hispanic origin? <input type="checkbox"/> Yes <input type="checkbox"/> No What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Are you a U.S. Citizen and a Wyoming resident for at least 1 year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Highest grade in school you completed: <i>circle one</i> 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+					
What is your household income <u>before</u> taxes? Monthly Income: \$ Yearly Income: \$ <input type="checkbox"/> Attach previous year's Income Tax Return			How many people live on this income?		
Family History *please refer to page 4 for common screening terms How many family members (parents, brothers, sisters, children) have been told they have colon cancer or rectal cancer? (<i>please circle</i>) 0 1 2 3+ Don't Know How many of those family members with colon cancer were under the age of 60? (<i>please circle</i>) 0 1 2 3+ Don't Know How many family members (parents, brothers, sisters, and children) have been told they have polyps in the colon? (<i>please circle</i>) 0 1 2 3+ Don't Know How many of those family members with polyps were under the age of 50? (<i>please circle</i>) 0 1 2 3+ Don't Know (See Other Side) How many family members (parents, brothers, sisters, and children) have been told they have other types of					

cancer?(*please circle*) 0 1 2 3+ Don't Know

What kind of cancer did they have? _____

Personal History

Have you ever had any of the following tests?

Fecal Occult Blood Test (FOBT) ☐ Yes ☐ No ☐ Don't Know Date ____/____/____

Was your exam positive or negative? ☐ Positive ☐ Negative

Double Contrast Barium Enema (DCBE) ☐ Yes ☐ No ☐ Don't Know Date ____/____/____

***Colonoscopy** ☐ Yes ☐ No ☐ Don't Know Date ____/____/____

Were there polyps removed? ☐ Yes ☐ No ☐ Don't Know

***Sigmoidoscopy** ☐ Yes ☐ No ☐ Don't Know Date ____/____/____

Were there polyps removed? ☐ Yes ☐ No ☐ Don't Know

*If polyps were removed during your colonoscopy or sigmoidoscopy, how did you doctor describe the polyp?

☐ Normal ☐ Pre-Cancerous ☐ Cancer ☐ Don't Know

☐ Other _____

Have you ever been told by a doctor, nurse, or other health professional that you have had:

Cancer of the colon or rectum ☐ Yes Date ____/____/____ ☐ No ☐ Don't Know

Crohns Disease ☐ Yes Date ____/____/____ ☐ No ☐ Don't Know

Familial Adenomatous Polyposis (FAP) ☐ Yes Date ____/____/____ ☐ No ☐ Don't Know

Hereditary Non Polyposis Colorectal Cancer (HNPCC) ☐ Yes Date ____/____/____ ☐ No ☐ Don't Know

Inflammatory Bowel Disease (IBD) ☐ Yes Date ____/____/____ ☐ No ☐ Don't Know

Ulcerative Colitis ☐ Yes Date ____/____/____ ☐ No ☐ Don't Know

Are you currently under a doctor's care for any of the above conditions? ☐ Yes ☐ No ☐ Don't Know

Insurance Information (*This does not affect your eligibility for this program; this question is for data purposes only. The WCCEDP serves Wyoming residents that are uninsured and underinsured*)

Do you currently have private insurance? ☐ Yes ☐ No

Does your insurance cover the entire cost of a colonoscopy? ☐ Yes ☐ No ☐ Don't Know

Do you have Medicare? ☐ No ☐ Yes ☐ Part A only? ☐ Part A & B

Primary Care Physician Information

Please tell us who your primary doctor is: _____

Name of clinic: _____ City: _____

Phone: _____

For office use only:

Approved _____

Date _____

Denied _____

Date _____



Informed Consent and Release of Medical Information

1. Read **both sides** of this page; and
2. Sign this page and include it with your Enrollment Application.

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I want to be a part of the Wyoming Colorectal Cancer Early Detection Program. I understand that I must fall within the income guidelines and meet various program criteria in order to be eligible for enrollment. I also understand that in order to take part in the program, I must sign below.

- If I am under 50 years of age, I know I cannot be a part of the program without a written referral by my physician;
- I understand that the program will look at my health history and tell me if I am eligible to participate;
- Based on my health history, I may receive screening and/or health education materials;
- I know that the program will cover the cost of colonoscopy at Wyoming Medicaid rate (based on a WCCEDP-approved CPT code set);
- I will talk with the clinic/ hospital about how I am going to pay for any tests or services that are not paid by the WCCEDP;
- The program may remind me when it is time for me to go to my screening exams and send me information by mail to help me learn more about my health.
- I understand that the program does not pay for complications, adverse events, or treatment if diagnosed with colon cancer or other conditions such as Crohns Disease or other diseases. The program's staff will assist me in finding the most appropriate treatment resources;
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal screening, diagnostic tests, and/or treatment services to the program;
- I understand that the program may follow up with my primary care doctor if my past medical records need to be reviewed;
- My name, address, and/or other personal information will be used only by the program. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources;
- Other information may be used for studies approved by the program and/or The Centers for Disease Control and Prevention for use by outside researchers to learn more about colon health. These studies will not use my name or personal information; and
- To assist me in making the best healthcare decisions, the program may share clinical and other healthcare information including lab results and health history with my healthcare providers.

Signature

Date

Please Print Name

____/____/_____
Date of Birth

(See Other Side)

Affidavit of Wyoming Residency



1. Read this page; and
 2. Sign this page and include it with your Enrollment Application.
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Affidavit

I, _____, swear or affirm under
(Please print your name)

penalty of perjury of the laws of the State of Wyoming that (check all that apply)

_____ I am a United States citizen

OR

_____ I am Permanent Resident but not a United States Citizen

_____ I have been a Wyoming Resident for at least 1 year

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit and a Wyoming Resident for at least 1 (one) year. I further acknowledge that making a false, fictitious or fraudulent statement or representation in this sworn affidavit is punishable under criminal laws of Wyoming.

Signature

Date

ID or Drivers License #